APS Healthcare VERMONT
VERMONT CHRONIC CARE INITIATIVE
Healthy Together

Vermont Chronic Care Initiative: Care Coordination Services

Indicators for Referring to DVHA Care Coordination:

- Intensive care coordination, one on one intervention required (e.g. home visits)
- Limited health literacy with respect to condition(s)
- Medical, behavioral, and/or psychosocial instability, leading to gaps in care
- Emerging needs identified that could destabilize future plans for health improvement (e.g. housing or financial insecurity impacting ability to manage health)

Eligibility Criteria:

- Be enrolled in a Medicaid program
- Individuals who have co-occurring conditions of substance abuse and/or mental health diagnoses may be especially good candidates
- High ER utilization, frequent hospitalizations, poly pharmacy and/or high predictability of future health care complications
- Not currently receiving other case management services (e.g. CMS covered case management such as CRT, Choices for Care/PACE and/or other waivers)
- Not currently residents of nursing homes or assisted living facilities
- Not have Medicare or Catamount Health Plan or be incarcerated.

Care Coordination Role: Overall responsibilities include: Advocacy, Assessment, Planning, Implementation, Coordination, Monitoring, Evaluation, and Outcome analysis. The care coordinators are Registered Nurses, Licensed Clinical Social Workers or Licensed Alcohol and Drug Abuse Counselors, and Medical Social Workers with direct and relevant experience in clinical delivery as well as case management experience in the community setting. The care coordinators:

- Facilitate access to a medical home and communication/coordination among service providers.
- Develop a plan of care for disease management based on the priority of both the provider and beneficiary, and social factors impacting health outcomes.
- Facilitate communication and coordination among beneficiary, PCP and specialty providers to support the treatment plan, including mental health and substance abuse providers.
- Support development of skill and confidence required for effective self-management of chronic condition via coaching, education, and/or referral to programs and/or services (Certified diabetic educators, Healthier Living Workshops).
- Refer to appropriate resources to reduce the socioeconomic barriers to health and health care, including access to safe and affordable housing, employment, food stamps, fuel assistance and transportation to health care providers for eligible beneficiaries as appropriate.

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Service Delivery Model: Combination of state and contracted staff.

- **Direct Service Staff**: State employed field staff of 18 licensed and non-licensed RNs, LiCSW/LADC and medical social workers to provide intensive case management services. Staff are co-located within AHS district offices, select high volume hospitals and PCP locations. APS contracted staff function as regional clinical practice specialists (5 RN's); and 2 staff SW's. Case loads range between 25 and 50 cases for intensive case management.
- **Population Selection**: Highest cost/highest risk individuals (top 5%) using stratification and predictive modeling for selection based on ED usage, inpatient stays, poly pharmacy, etc…and 'intervenable' conditions; as well as community based referrals from hospital ED, discharge planners/case managers, PCP's, CHT's, homeless shelters, MH agencies, etc...
- **Individual and population based approaches**: VCCI staff provide one:one case management and care coordination for highly complex cases to reduce barriers and/or gaps in care and improve access as well as adherence to recommended treatment; APS staff provide disease specific 'health registries' by provider/practice to support evidence based care, NCQA goals for certification as an advanced practice medical home, outreach and QI efforts.
- **Assessments and Care Plan Development:** Holistic approach with associated psycho-social, behavioral health and disease specific screening tools to develop POC. Focus on establishing Medical Home, service coordination and supporting treatment adherence including financial, health literacy, cognition and/or other barriers that impact ability to successfully self-manage.
- **Transition in Care:** Short term intensive services with transitional support to other community based services for sustainable change including Blueprint CHT's, Choices for Care and CRT services.

Select Outcomes for FY2010: VCCI intervened population (3,245) vs. non-intervened.

- **ED utilization**: decrease by 6%
- **Inpatient utilization**: decreased by 11%
- **Asthma**: enhanced rate of bronchodilator prescriptions dispensed by 16% (36.4% vs. 52.5%)
- **Depression**: enhanced rate 180 day anti-depressant treatment by 19% (47.6% vs. 65.5%)
- **Diabetes**: enhanced rate of HbA1c testing by 15% (66% vs. 81.1%); lipid testing by 16.5% (55.7% vs.72.2%)
- **CHF**: enhanced rate of ACE/ARB dispensing by 16.5% (38.2% vs. 54.7%); enhanced rate of Beta blockers by 20.2% (40.3% vs. 60.5%) and diuretics by 23.5% (35.2% vs 58.7%)

Provider Payments:

- **Enhanced PCP payments:** $150.00/case for collaboration with VCCI field staff (billable up to twice annually/member)

Financial Model:

- **APS Contract – FY 2012-2014:** Full risk contract with a 2:1 return on investment (roughly $5 million dollars)